MDR Tracking Number: M5-04-1901-01

Under the provisions of Section 413.031 of the Texas Workers' Compensation Act, Title 5, Subtitle A of the Texas Labor Code, effective June 17, 2001 and Commission Rule 133.305 titled Medical Dispute Resolution - General and 133.308 titled Medical Dispute Resolution by Independent Review Organizations, the Medical Review Division (Division) assigned an IRO to conduct a review of the disputed medical necessity issues between the requestor and the respondent. The dispute was received on February 26, 2004.

In accordance with Rule 133.307 (d), requests for medical dispute resolution are considered timely if it is filed with the division no later than one (1) year after the date(s) of service in dispute. The Commission received the medical dispute resolution request on 02-26-04, therefore the following date(s) of service are not timely: 10-01-02 through 02-05-03.

Based on correspondence received from the requestor, Norseman Bone and Joint, dated 07-27-04, CPT codes 99080 and 97122 for date of service 04-03-04 have been withdrawn.

The Division has reviewed the enclosed IRO decision and determined that **the requestor did not prevail** on the majority of the medical necessity issues. Therefore, the requestor is not entitled to reimbursement of the IRO fee.

Based on review of the disputed issues within the request, the Medical Review Division has determined that **medical necessity was the only issue** to be resolved. The electric stimulation, hot/cold pack therapy, office visits, joint mobilization, massage therapy, manual traction, myofascial release, prolonged evaluation, analyze clinical data, chiropractic manipulation treatment spinal, ultrasound and manual therapeutic techniques from 03-05-03 through 04-11-03 **were found** to be medically necessary. The electric stimulation, hot/cold pack therapy, office visits, joint mobilization, massage therapy, manual traction, myofascial release, prolonged evaluation, analyze clinical data, chiropractic manipulation treatment spinal, ultrasound and manual therapeutic techniques from 04-15-03 through 09-24-03 **were not found** to be medically necessary. The respondent raised no other reasons for denying reimbursement for the above listed services.

On this basis, and pursuant to §§402.042, 413.016, 413.031, and 413.019 of the Act, the Medical Review Division hereby ORDERS the respondent to pay the unpaid medical fees in accordance with the fair and reasonable rate as set forth in Commission Rule 133.1(a)(8) plus all accrued interest due at the time of payment to the requestor within 20-days of receipt of this Order. This Order is applicable to dates of service 03-05-03 through 04-09-03 in this dispute.

The respondent is prohibited from asserting additional denial reasons relative to this Decision upon issuing payment to the requestor in accordance with this Order (Rule 133.307(j)(2)).

This Order is hereby issued this 16th day of August 2004.

Patricia Rodriguez
Medical Dispute Resolution Officer
Medical Review Division
PR/pr

NOTICE OF INDEPENDENT REVIEW DECISION

July 9, 2004

Re: IRO Case # M5-04-1901, amended 8/11/04
IRO Certificate #4599

Texas Worker's Compensation Commission:

___ has been certified as an independent review organization (IRO) and has been authorized to perform independent reviews of medical necessity for the Texas Worker's Compensation Commission (TWCC). Texas HB. 2600, Rule133.308 effective January 1, 2002, allows a claimant or provider who has received an adverse medical necessity determination from a carrier's internal process, to request an independent review by an IRO.

In accordance with the requirement that TWCC assign cases to certified IROs, TWCC assigned this case to ___ for an independent review. ___ has performed an independent review of the proposed care to determine if the adverse determination was appropriate. For that purpose, ___ received relevant medical records, any documents obtained from parties in making the adverse determination, and any other documents and/or written information submitted in support of the appeal.

The case was reviewed by a physician who is a Board certified in Neurological Surgery, and who has met the requirements for TWCC Approved Doctor List or has been approved as an exception to the Approved Doctor List. He or she has signed a certification statement attesting that no known conflicts of interest exist between him or her and any of the treating physicians or providers, or any of the physicians or providers who reviewed the case for a determination prior to referral to ___ for independent review. In addition, the certification statement further attests that the review was performed without bias for or against the carrier, medical provider, or any other party to this case.

The determination of the ___ reviewer who reviewed this case, based on the medical records provided, is as follows:

<u>Medical Information Reviewed</u>

1. Table of disputed services

2. Explanation of benefits
3. TWCC 69 Report of impairment rating 3/23/04
4. Review reconsideration 1/9/04
5. Chiropractic review 6/20/03
6. Letter of medical necessity 4/22/04
7. Letter from treatment provider 8/18/03,5/29/03
8. Physical therapy review 3/11/04
9. Neurosurgical note 3/9/04
10. Spine specialist's notes
11. D.C. notes and reports
12. Physical therapy initial evaluation 1/6/03
13. Treatment records
14. Operative report 11/5/03
15. NCS report 1/20/03
16. Cervical discogram report 4/11/03
17. X-ray cervical spine report 4/3/03
18. ROM report 6/12/02
19. Pain management notes, and injection records

History

The patient is a 48-year-old female who in ___ was driving a truck in high winds and noticed the development of pain in her neck and mid-back. Physical therapy and chiropractic treatment were of no significant help. An MRI on 5/14/02 showed a C5-6 poterior protrusion of the disk toward the left. Subsequent to that, the patient continued physical therapy without significant help. The patient experienced what was described as "an exacerbation/new injury in 01/2003" after returning to work. Discographic evaluation on 4/11/03 suggested concordant pain at C4-5, C5-6 and C6-7, but was especially severe at C5-6, corresponding to what had been found on MRI. An anterior cervical diskectomy and fusion at the C5-6 level had been recommended by more than one surgeon before the discographic evaluation.

Requested Service(s)

Elec stim, hot/cold pack ther, OV, joint mobil, mas ther, traction manual, myofs rel, prol eval, analyze clinical data, chiro man treat spinal, ultrasound, man ther tech 3/5/03 – 9/24/03

Decision

I disagree with the carrier's decision to deny the requested services through 4/11/03.

I agree with the denial of services after 4/11/03.

Rationale
The records provided suggest that the requested services in March, and prior to the discographic evaluation on 4/11/03 were probably indicated. The patient had apparently suffered additional injury, which had worsened symptoms. The physical therapy notes, however indicate that therapy was not of much benefit, and subsequent to 4/11/03 the patient was awaiting surgery. If the therapy had been helpful during the wait for surgical approval, it might have been appropriate, but that was not the case.

This medical necessity decision by an Independent Review Organization is deemed to be a Commission decision and order.